Department of Veterans Affairs

Capital Asset Realignment for Enhanced Services

VISN 5

Market Plans

Attention

The VISNs developed the initial CARES Market plans under direction from the National CARES Program Office (NCPO). After these were submitted by the VISN, they were utilized as the basis for the National CARES Plan. However, the CARES National Plan includes policy decisions and plans made at the National Level which differ from the detailed Network Market Plans. Therefore, some National policy decisions that are in the National Plan are not reflected in the Network Market Plans. These initial VISN Market Plans have detailed narratives and data at the VISN, Market and Facility level and are available on the National CARES Internet Site : <<http://www.va.gov/CARES/>>.

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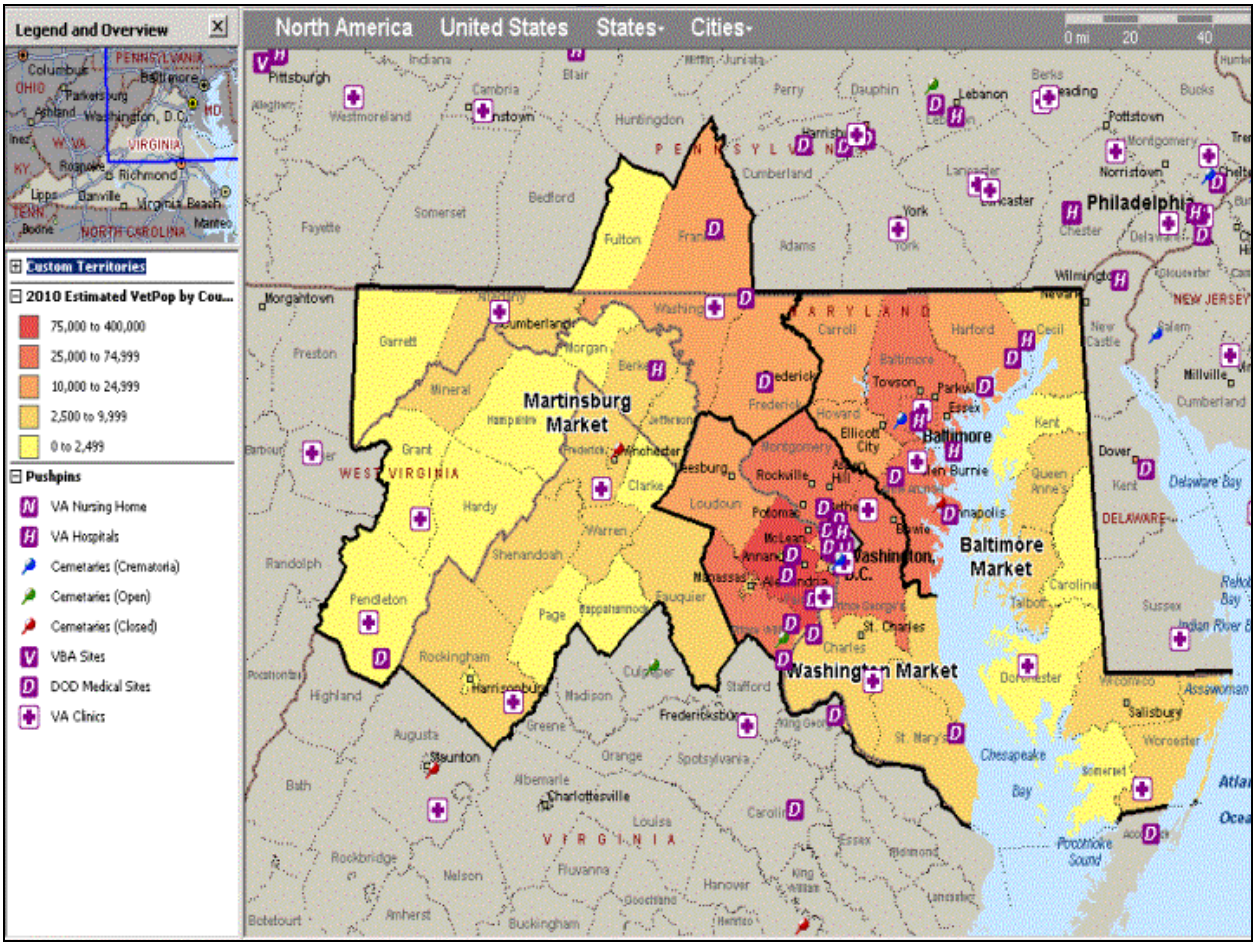
I. VISN Level Information

A. Description of the Network/Market/Facilities

1. Map of VISN Markets



2. Market Definitions

Market Designation: The VA Capitol Health Care Network (VISN 5) is proposing three CARES markets as follows:

Market	Geographic Area	Rationale	Shared Counties
Baltimore Market **Code: 5A**	15 counties in Maryland including the Maryland Eastern Shore and counties surrounding Baltimore 15 Total Counties	The VA Maryland Health Care System (VAMHCS), consisting of the Baltimore, Fort Howard and Perry Point medical centers, serves the Baltimore Market. VAMHCS supports five CBOCs, two of which serve the Maryland Eastern Shore. Of the total 15 counties in this Market, the Eastern Shore comprises 8 rural counties, accounting for 13.3% of the market enrollees. The Bay Bridge provides access from the Eastern Shore counties with an identifiable referral pattern to the Baltimore Medical Center. The remaining 7 counties surround the Baltimore Metro area and the northeastern quadrant of Maryland along US 95. **Facilities:** VA Maryland Healthcare System (VAMHCS): Baltimore, Perry Point, Fort Howard	VAMHCS provides services to enrollees from bordering counties in Delaware and Pennsylvania (VISN 4), but not to the extent to justify development of a shared market.
Washington Market **Code: 5C**	5 counties in Maryland, 9 counties in Virginia, and 1 District of Columbia encompassing the Washington Metropolitan area 15 Total Counties	VAMC Washington serves the Washington Market. Washington supports two CBOCs. VAMC Washington is the preferred site of care for all 15 counties comprising the Washington metropolitan area. (Please note: Although the Charlotte Hall CBOC is linked with the Baltimore medical center, the three rural southern counties of Prince George's County it serves were included in the Washington Market since the enrollee preferred site of care from these counties is VAMC Washington.) **Facilities:** Washington	Washington provides services to enrollees from neighboring Virginia counties in VISN 6, but not to the extent to justify development of a shared market.

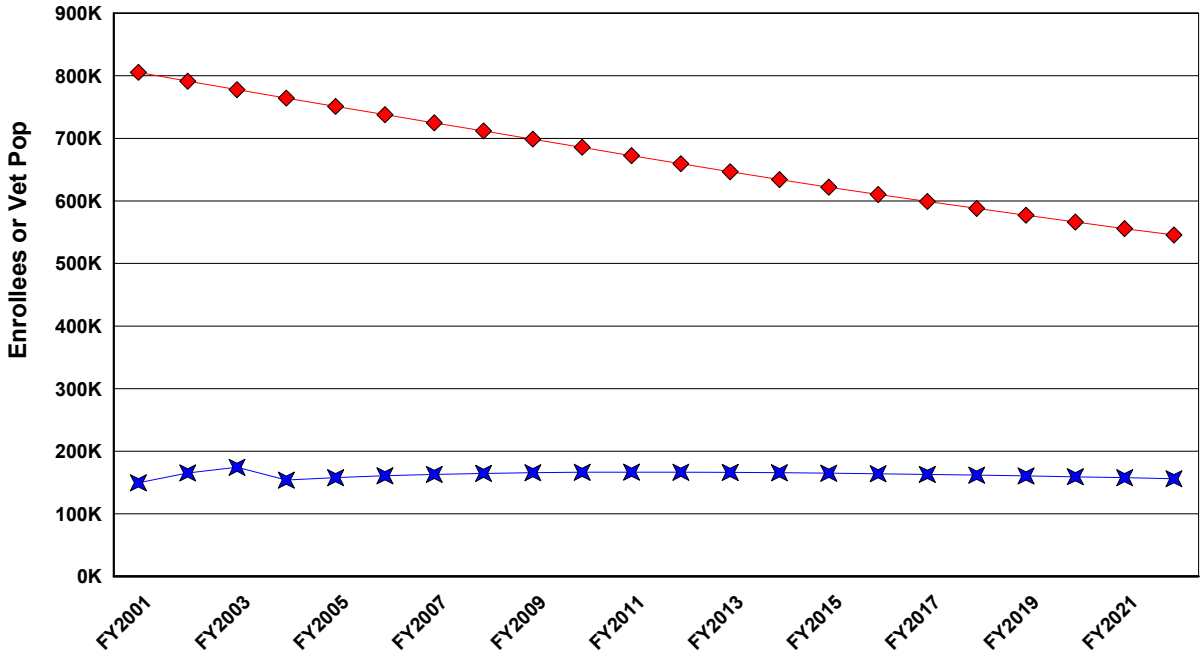
Martinsburg Market **Code: 5B**	5 counties in Maryland, 8 counties in Virginia, 2 counties in Pennsylvania and 8 counties in West Virginia 23 Total Counties	VAMC Martinsburg serves the Martinsburg Market. Martinsburg supports 6 CBOCs. Although the Martinsburg Market is the largest of the three markets in size, it provides services to less than 20% of the network enrollees. Of the 23 counties comprising the Martinsburg Market, 8 are urban, 8 are rural, and 7 were identified as highly rural (less than 50 vet pop/square mile). **Facilities:** Martinsburg	Martinsburg provides services to enrollees from neighboring VISN 4 counties in Pennsylvania and neighboring VISN 6 counties in Virginia, but not to the extent to justify development of a shared market.

3. Facility List

VISN : 5				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Baltimore				
512 Baltimore	✔	✔	✔	-
512GB Southern Maryland	✔	-	-	-
512GC Glen Burnie	✔	-	-	-
512GD Loch Raven	✔	-	-	-
512GF Fort Howard CBOC	✔	-	-	-
Fort Howard				
512A4 Fort Howard	✔	-	-	-
Martinsburg				
613 Martinsburg	✔	✔	-	-
613GA Cumberland	✔	-	-	-
613GB Hagerstown	✔	-	-	-
613GC Stephens City	✔	-	-	-
613GD Franklin	✔	-	-	-
613GE Petersburg	✔	-	-	-
613GF Harrisonburg	✔	-	-	-
Perry Point				
512A5 Perry Point	✔	✔	-	-
512GA Cambridge	✔	-	-	-
Washington				
688 Washington	✔	✔	✔	-
688GA Alexandria	✔	-	-	-
688GB Southeast Washington	✔	-	-	-
688GC Landover/Greenbelt (Prince Georges County)	✔	-	-	-

4. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



5. Planning Initiatives and Collaborative Opportunities

a. Effective Use of Resources

Effective Use of Resources		
PI?	**Issue**	**Rationale/Comments Re: PI**
N	Small Facility Planning Initiative	Fort Howard was converted to a CBOC in 2002.
Y	Proximity 120 Mile Tertiary	The following medical centers providing tertiary hospital care are within a 120 mile radius. While the two major metropolitan areas of Baltimore and Washington DC support two facilities, VISN 5 will explore Centers of Excellence between the two sites. Baltimore, MD and Washington, DC.
N	Proximity 120 Mile Tertiary	Baltimore, MD and Philadelphia, PA (VISN 4). The travel time distances with traffic patterns are prohibitive to shared services.
N	Proximity 120 Mile Tertiary	Washington, DC and Richmond, VA (VISN 6). The travel time distances with traffic patterns are prohibitive to shared services.
N	Proximity 60 Mile Acute	Baltimore, MD and Washington, DC. These two major metropolitan cities justify the need for two sites providing acute services.
N	Proximity 60 Mile Acute	Perry Point, MD and Baltimore, MD. Perry Point and Baltimore have different missions that do not overlap. Perry Point is primarily LTC and Psychiatry.
N	Proximity 60 Mile Acute	Perry Point, MD and Wilmington, DE (VISN 4). With the recent VA Maryland HCS mission changes in FY2002, the Perry Point mission is LTC and Psychiatry. Perry Point is not an acute care hospital.
Y	Vacant Space	All VISNs will need to explore options and develop plans to reduce vacant space by 10% in 2004 and 30% by 2005.

b. Special Disabilities

Special Disability Programs		
PI?	**Other Issues**	**Rationale/Comments**
N	Blind Rehabilitation	
N	Spinal Cord Injury and Disorders	

c. Collaborative Opportunities

Collaborative Opportunities for use during development of Market Plans		
CO?	**Collaborative Opportunities**	**Rationale/Comments**
Y	Enhanced Use	National Top 15-Use Lease Opportunities: Fort Howard, MD and Washington, DC. Possible Enhanced-Use opportunities at Perry Point, MD.
Y	VBA	Co-Location at Washington, DC OneVA Vocational Rehabilitation Service expansion at Martinsburg and new development at Baltimore, MD and Washington, DC.
N	NCA	No sites identified.
Y	DOD	There are potential DoD opportunities with the VA that were found in V5 for review and analysis. •Share VA technology for Electronic Medical Record for improved VA/DoD communications. •Joint Venture Community Based Outpatient Clinics at Fort Belvoir, Fort Detrick and Fort Meade. •Investigate opportunities to develop Centers of Excellence. •Review contracted medical care for possible joint VA/DoD actions. •Possible VA/DoD Conference/Education Center in the DC area. •Investigate opportunities for VA/DoD Reference Lab. •Sharing High Tech/High Cost equipment. •Sharing of laundry services and incinerator for medical waste. •Joint venture working with US VETS for Residential Care Housing.

d. Other Issues

Other Gaps/Issues Not Addressed By CARES Data Analysis		
PI?	**Other Issues**	**Rationale/Comments**
Y	Nursing Home Care Facility Condition Planning Initiative	VISN 5 recommends a Planning Initiative to replace the Perry Point Nursing Home Care Unit. CARES NH/Intermediate data, although not being used in this round to develop Planning Initiatives, does support the need to sustain this program. The Facility Condition Assessment scores for the Nursing Home Unit at Perry Point averaged D (failing), which indicate system deficiencies. Space and Functional scores averaged 2 (unacceptable) indicating poor functional layout
Y	Inpatient Mental Health Realignment Planning Initiative	VISN 5 would like to develop a VISN-wide Planning Initiative for inpatient mental health services. The CARES data does not reflect the impact on the large psychiatric and homeless populations in the Washington/ Baltimore areas.

e. Market Capacity Planning Initiatives

Baltimore Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	149,782		52,282	**35%**	14,475	**10%**
	Treating Facility Based **	158,734		46,375	**29%**	9,336	**6%**
Specialty Care	Population Based *	124,373		127,525	**103%**	93,174	**75%**
	Treating Facility Based **	126,869		121,523	**96%**	88,497	**70%**
Psychiatry	Population Based *	57,445		(3,252)	**-6%**	(8,973)	**-16%**
	Treating Facility Based **	80,960		(1,343)	**-2%**	(9,596)	**-12%**

Marinsburg Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	90,758		31,967	**35%**	16,811	**19%**
	Treating Facility Based **	104,602		44,162	**42%**	27,729	**27%**
Specialty Care	Population Based *	64,721		50,661	**78%**	41,021	**63%**
	Treating Facility Based **	64,911		67,114	**103%**	59,330	**91%**
Mental Health	Population Based *	29,296		15,572	**53%**	8,448	**29%**
	Treating Facility Based **	41,388		14,726	**36%**	8,821	**21%**

Washington Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	134,320		57,987	**43%**	48,425	**36%**
	Treating Facility Based **	132,263		66,516	**50%**	51,946	**39%**
Specialty Care	Population Based *	125,444		130,712	**104%**	137,560	**110%**
	Treating Facility Based **	124,352		141,652	**114%**	141,676	**114%**
Psychiatry	Population Based *	23,349		6,744	**29%**	1,641	**7%**
	Treating Facility Based **	7,451		2,966	**40%**	145	**2%**

* – Population Based: Sum of the workload demand based on where the enrollee lives. Sum of the workload projections for the enrollees living in the counties geographically located in the Market. This is not necessarily where they go for care.

** – Treating Facility Based: Sum of the workload demand based on where the enrollee goes for care. Sum of the facility data for the facilities geographically located in the Market. (Due to the traffic or ever referral patterns, the population based and treating facility projections will not match at the market level, although nationally they will be equal)

*** – Modeled data is the Consultants projection based on what the workload **would have been if adjusted for community standards**.

6. Stakeholder Information

Summary narrative on key stakeholder issues by Market, and how the comments/concerns were incorporated in the Market Plan.

Stakeholder Narrative:

The VISN Office presented CARES progress reports at MAC meetings attended by the Veteran Service Organizations, Union Partners, Congressional Staff, Medical Center Directors, Network Director, and VISN staff. Additionally, a CARES council was formed to work with our stakeholders on a more personal level to educate and inform them of the CARES process. The VISN staff also traveled to various Voluntary Service Organization meetings to present the CARES PI's and answer local questions. VISN 5 Markets were broken into the three Medical Center Catchment areas; this made the local presentations more meaningful and easy to understand. At these outreach presentations the Veteran's Service organizations and other stakeholders were informed that the three primary PIs were in Outpatient Specialty Care, Outpatient Primary Care, and Outpatient Mental Health. Planning Initiatives where expansion of services and moving of services to areas most needed by veterans created positive feedback. Our veteran service organization approved all efforts that would build greater communication and cooperation effort between DoD and VA. This positive feedback reinforces and encourages the VISN staff and Medical Center staff to be proactive in these efforts.

7. Collaboration with Other VISNs

Summary narrative of collaborations with neighboring VISNs, and result of collaborations. Include overview of Proximity issues across VISNs.

Collaboration with Other VISNs Narrative:

Current referral patterns between markets will remain intact. Baltimore and Washington serve as tertiary care referral centers for the Martinsburg Market. As part of the Proximity Planning Initiative, Baltimore and Washington will continue to pursue the consolidation of small volume subspecialty services.

Domiciliary Care, currently consolidated at the Martinsburg VAMC, will retain overall VISN capacity levels but will shift a part of the Martinsburg program to the Washington Market to meet the needs of the large homeless population in the DC area.

In addition, the VA Capitol Health Care Network also has established referral patterns that we will continue to utilize with the VA Stars and Stripes Healthcare Network VISN 4 for Blind Rehabilitation patient treatment, and with the VA Mid-Atlantic Health Care Network VISN 6 for the treatment of Spinal Cord Injury patients. The veteran patient growth in these specialty care areas are projected to remain relatively stable with slow projected growth rates out to FY 2022.

B. Resolution of VISN Level Planning Initiatives

1. Proximity Planning Initiatives (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

Proximity Narrative:

Executive Summary (Full analysis on CARES Portal):

As part of the CARES process, medical centers located within 35 aerial miles must complete an analysis to identify opportunities for cost efficiencies in combining clinical and administrative services, as part of the proximity planning initiatives to eliminate unnecessary duplication.

This review takes into consideration that both facilities are located in large urban areas and have a significant enrollment, which projects an increase over the next twenty years. The facilities are highly complex medical institutions that serve separate and distinct, major metropolitan populations. Additionally, both facilities have numerous teaching affiliations and are major resources to medical education. Present capacity makes it impossible to absorb the other facility's workload, without duplicating space, and neither site can accommodate the required space necessary to integrate the facilities. Although both facilities are within thirty-five mile of each other, population density and traffic patterns support maintaining both facilities.

Operating under the above premise, two alternatives were considered, Alternative 1, Option C, " Maintain both facilities but consolidate services/integrate facilities", and Alternative 2, Option A, "Retain both facilities with no additional consolidation of services". Alternative 1, Option C is the preferred choice as it maintains the current high level of integration and shared services while continuing to investigate clinical and administrative program efficiencies, e.g. radiation therapy, brachytherapy, warehouse functions. Alternative 2, Option A, is not preferred because although it maintains the current high level of integration and shared services the option does not identify additional future efficiencies that would result in responsible fiscal management.

Both Facilities are teaching hospitals, providing a full range of patient care services, with state-of-the-art technology as well as education and research. Comprehensive health care is provided through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. Each facility has a 120-bed nursing home care facility that provides extended care rehabilitation, post acute

care, psycho-geriatric care, hospice care, and general nursing home care. The medical centers are located in large urban areas and serve as tertiary referral centers within the VA Capitol Health Care Network.

As stated in the mission overview both facilities are located in large urban areas and have a large number of enrollees, which is projected to increase over the next twenty years. Additionally, both facilities have active teaching affiliations that are major resources to medical education. At present, both facilities are highly developed, complex medical institutions that serve separate and distinct, major metropolitan populations.

Currently both facilities' workload demand exceeds present capacity, both in human resources as well as in clinical space. This makes it impossible to absorb the other facility's workload, without duplicating space. Neither site can accommodate the required space necessary to completely integrate the facilities.

Although both facilities are within thirty-five miles of each other, population density and traffic patterns support maintaining both facilities. The average driving time between the facilities is 90 minutes. Although both cities have mass transportation systems, there is limited crossover between the systems. CARES data shows that over 95% of veteran's seek care at the facility within their market.

2. Special Disability Planning Initiative (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

Your analysis should include the following:

1. Describe the impact that the planning initiative will have on the mandated funding levels for special disability programs:

    - SCI
    - Blind Rehab
    - SMI
    - TBI
    - Substance Abuse
    - Homeless
    - PTSD

2. Discuss how the planning initiative may affect, complement or enhance special disability services.

3. Describe any potential stakeholder issues revolving around special disabilities related to the planning initiative.

Special Disability Narrative:

Spinal Cord Injury – The VA Capitol Health Care Network does not have a comprehensive Spinal Cord Injury program, but does provide follow up care after patients have been discharged from the Richmond VAMC (VISN 6) SCI Center. The Network will continue to refer SCI patients to the Richmond VAMC SCI Center in VISN 6.

Blind Rehabilitation – The VA Capitol Health Care Network provides services to blind veterans, but does not have a Blind Rehabilitation Center. We will continue to utilize our current referral relationships with the Blind Rehabilitation Centers in VISNs 4 and 6 as necessary. The CARES demand model projects that VISN 5 blind rehabilitation workload will remain stable with very little overall growth in the demand for this specialty care. The blind rehabilitation projected veteran enrollments display a slow progression from 771 veterans in FY 2001 to only 1,225 veterans by 2022. In addition, blind rehabilitation bed projections reveal a need for only 2 additional beds from 4 to 6 beds by FY 2012 and FY 2022.

C. VISN Identified Planning Initiatives

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria. (See Chapter 5 Attachment 3 guidebook and Market Plan handbook.)

Your analysis should include the following:

1. List all of the VISN PIs and provide a short summary. Post the entire summary documentation on the portal.

VISN Planning Initiatives Narrative:

Complete narratives for the two (2) VISN Identified PIs can be found on the VSSC CARES Portal.

1. NURSING HOME FACILITY CONDITION Summary:

The 130-Bed Replacement Nursing Home Care Unit at Perry Point is a priority Major construction project for VISN 5. The Millennium Bill mandates facilities maintain current levels of nursing home care beds. Our network does not have appropriate alternative vacant space to accommodate this program. It is imperative this project move forward to ensure a high level of patient satisfaction and service.

Currently the 130-Bed nursing home care program at Perry Point operates in two separate buildings. Building 9H contains 80 beds, and is an aging 79-year old dilapidated building that is poorly configured. The infrastructure, functional layout, and fire and safety features of Building 9H are inadequate for the purpose of housing inpatients. Building 14H contains 50 beds, and was recently renovated. To improve efficiencies, the network supports constructing a new 130-bed replacement nursing home. Building 9H would be demolished, and Building 14H would be reassigned to accommodate mental health beds currently located in Building 24H, another 56-year old building requiring major renovations. Building 24H would be demolished or outleased.

2. INPATIENT MENTAL HEALTH REALIGNMENT Summary

The Network requested our Mental Health Service Line to develop a VISN-wide Planning Initiative for inpatient mental health services. The goal was to review current referral patterns for inpatient bed services and determine if access could be improved and enhancements made to the mental health continuum of services. The VISN 5 Mental Health Service line developed two planning initiatives to improve patient access to inpatient mental health programs through the realignment of mental health beds between markets. One recommendation was to realign 77 Domiciliary beds between Martinsburg

and Washington, and the other recommendation was to realign 22 Inpatient Psychiatry beds between Perry Point and Washington.

The Martinsburg 312-bed Domiciliary currently serves patients throughout the network. A review of data identified the majority of Martinsburg Domiciliary patients reside in the Washington and Baltimore markets. The Baltimore market has a 50-Bed Domiciliary in Perry Point and the Washington market has no Domiciliary beds. Of the 312-beds at Martinsburg, 77 beds are currently housed in structures constructed in WWII. A previous feasibility study identified the structures as not worth renovating. With new construction as the viable alternative for replacing the 77 beds at Martinsburg, the Mental Health Service Line recommended the beds be relocated to Washington. The preferred alternate being pursed by Washington is to locate the 77-bed Domiciliary program through a Joint Venture with the Armed Services Retirement Home, located directly across the street from the Washington VAMC. The second alternate would be to lease space in the community.

D. VISN Level Data Summary of Post Market Plan (Workload, Space, & Costs)

1. Inpatient Summary

a. Workload

	BDOC Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
INPATIENT CARE	Baseline FY 2001 BDOC	FY 2012 BDOC	FY 2022 BDOC	In House BDOC	Other BDOC	In House BDOC	Other BDOC	Net Present Value
Medicine	70,767	80,021	67,484	73,228	6,909	65,374	2,214	$ (67,786,837)
Surgery	22,271	26,429	22,304	26,028	403	21,941	364	$ (2,389,806)
Psychiatry	94,880	99,334	86,005	93,336	6,101	82,923	3,185	$ 26,800,569
PRRTP	456	456	456	73	383	73	383	$ (390,611)
NHCU/Intermediate	308,604	308,604	308,604	192,421	116,183	192,421	116,183	$ 65,718,365
Domiciliary	114,681	114,681	114,681	92,935	21,746	92,935	21,746	$ 62,479,704
Spinal Cord Injury	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	$ -
Total	**611,659**	**629,525**	**599,534**	**478,021**	**151,725**	**455,667**	**144,075**	**$ 84,431,384**

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
INPATIENT CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Medicine	123,098	163,412	137,828	152,315	135,978	$ (67,786,837)
Surgery	48,896	46,130	39,164	46,897	39,759	$ (2,389,806)
Psychiatry	90,235	172,611	147,940	162,554	143,587	$ 26,800,569
PRRTP	59,320	59,320	59,320	17,978	17,978	$ (390,611)
NHCU/Intermediate	233,130	266,946	266,946	293,130	293,130	$ 65,718,365
Domiciliary	163,356	150,726	150,726	150,726	150,726	$ 62,479,704
Spinal Cord Injury	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	$ -
Total	**718,035**	**859,145**	**801,923**	**823,600**	**781,158**	**$ 84,431,384**

2. Outpatient Summary

a. Workload

	Clinic Stop Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
Outpatient CARE	Baseline FY 2001 Stops	FY 2012 Stops	FY 2022 Stops	In House Stops	Other Stops	In House Stops	Other Stops	Net Present Value
Primary Care	395,598	552,650	484,610	520,765	32,751	458,428	26,909	$ 34,910,685
Specialty Care	316,130	646,419	605,633	537,222	110,025	501,436	104,936	$ (55,531,611)
Mental Health	339,117	354,226	345,712	335,466	19,685	327,421	19,192	$ (10,006,155)
Ancillary& Diagnostic	435,654	793,639	769,869	463,641	331,328	439,871	331,204	$ 1,701,637
Total	**1,486,499**	**2,346,934**	**2,205,824**	**1,857,094**	**493,789**	**1,727,156**	**482,241**	**$ (28,925,444)**

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
Outpatient CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Primary Care	186,889	293,909	256,422	285,625	250,147	$ 34,910,685
Specialty Care	301,558	728,829	682,122	612,267	570,682	$ (55,531,611)
Mental Health	125,160	215,175	209,125	209,270	203,219	$ (10,006,155)
Ancillary& Diagnostic	244,195	532,826	517,997	339,202	321,627	$ 1,701,637
Total	**857,802**	**1,770,738**	**1,665,666**	**1,446,364**	**1,345,675**	**$ (28,925,444)**

3. Non-Clinical Summary

	Space Projections (from demand)			Post CARES (from solution)		
NON-CLINICAL	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Research	142,387	142,387	142,387	312,055	312,055	$ (33,177,692)
Admin	1,003,243	1,581,047	1,488,283	1,032,543	1,032,543	$ (5,380,028)
Outleased	334,067	334,067	334,067	334,067	334,067	N/A
Other	293,027	293,027	293,027	195,627	195,627	$ (1,978,404)
Vacant Space	377,381	-	-	156,401	178,432	$ 154,760,179
Total	**2,150,105**	**2,350,528**	**2,257,764**	**2,030,693**	**2,052,724**	**$ 114,224,055**

II. Market Level Information

A. Baltimore Market

1. Description of Market

a. Market Definition

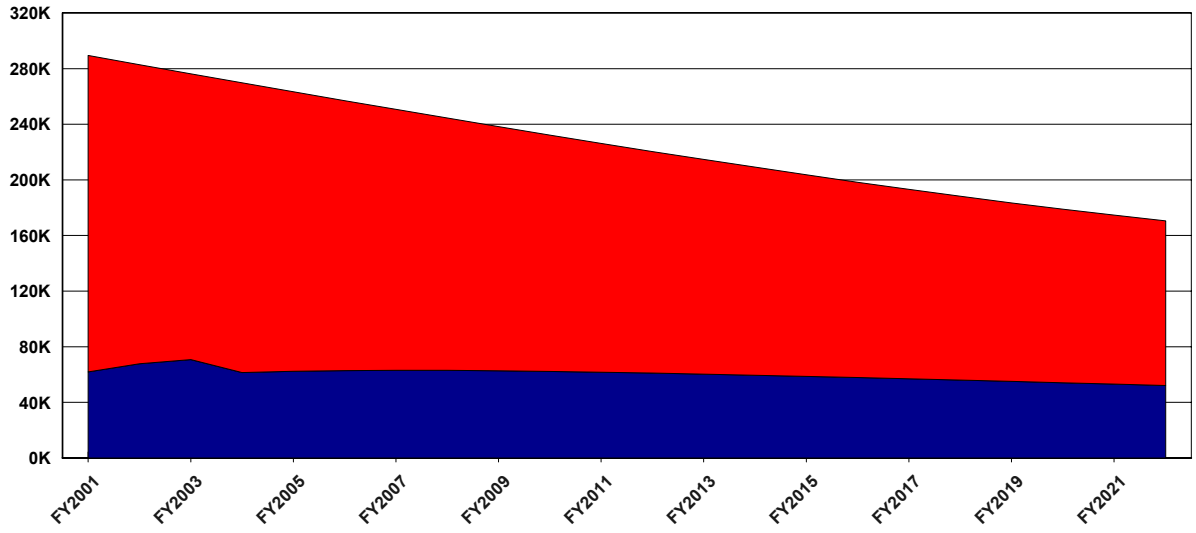
Market	Geographic Area	Rationale	Shared Counties
Baltimore Market Code: 5A	15 counties in Maryland including the Maryland Eastern Shore and counties surrounding Baltimore 15 Total Counties	The VA Maryland Health Care System (VAMHCS), consisting of the Baltimore, Fort Howard and Perry Point medical centers, serves the Baltimore Market. VAMHCS supports five CBOCs, two of which serve the Maryland Eastern Shore. Of the total 15 counties in this Market, the Eastern Shore comprises 8 rural counties, accounting for 13.3% of the market enrollees. The Bay Bridge provides access from the Eastern Shore counties with an identifiable referral pattern to the Baltimore Medical Center. The remaining 7 counties surround the Baltimore Metro area and the northeastern quadrant of Maryland along US 95. Facilities: VA Maryland Healthcare System (VAMHCS): Baltimore, Perry Point, Fort Howard	VAMHCS provides services to enrollees from bordering counties in Delaware and Pennsylvania (VISN 4), but not to the extent to justify development of a shared market.

b. Facility List

VISN : 5				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Baltimore				
512 Baltimore	✔	✔	✔	-
512GB Southern Maryland	✔	-	-	-
512GC Glen Burnie	✔	-	-	-
512GD Loch Raven	✔	-	-	-
512GF Fort Howard CBOC	✔	-	-	-
Fort Howard				
512A4 Fort Howard	✔	-	-	-
Perry Point				
512A5 Perry Point	✔	✔	-	-
512GA Cambridge	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Baltimore Market			**Februrary 2003 (New)**			
Market PI	**Category**	**Type Of Gap**	**FY2012 Gap**	**FY2012 %Gap**	**FY2022 Gap**	**FY2022 %Gap**
	Access to Primary Care (# of enrollees)					
	Access to Hospital Care (# of enrollees)					
	Access to Tertiary Care (# of enrollees)					
PI	Specialty Care Outpatient Stops	Population Based	**127,527**	**103%**	**93,176**	**75%**
		Treating Facility Based	**121,527**	**96%**	**88,502**	**70%**
PI	Psychiatry Inpatient Beds	Population Based	-10	-6%	**-29**	-16%
		Treating Facility Based	-4	-2%	**-31**	-12%
PI	Primary Care Outpatient Stops	Population Based	**52,281**	**35%**	14,476	10%
		Treating Facility Based	**46,377**	**29%**	9,341	6%
	Medicine Inpatient Beds	Population Based	0	0%	**-24**	-23%
		Treating Facility Based	0	0%	**-24**	-22%
	Surgery Inpatient Beds	Population Based	0	1%	-8	-23%
		Treating Facility Based	2	6%	-6	-17%
	Mental Health Outpatient Stops	Population Based	N/A	N/A	N/A	N/A
		Treating Facility Based	N/A	N/A	N/A	N/A

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

On March 18, 19, and 25, 2003, the VA Veterans Service (VAVS) Organizations were presented with the VA Maryland Health Care Systems (VAMHCS) CARES Planning Initiatives (PI) at the quarterly (VAVS) meeting. At that time the Veteran's Service organizations were informed that the three primary PIs were in Outpatient Specialty Care, Outpatient Primary Care, and Outpatient Mental Health. Due to the nature of the Planning Initiatives expansion of services to veterans in these three areas, the feedback was positive. The Service Organizations do express concern that the CARES process may reduce service to Veterans nation wide, but they were reassured that the enrollment and stops data for VAMHCS showed periods of growth and the need for services over the next 20 year period. There was some concern from the stakeholders that the CARES model does not address the need for additional FTEE that would be necessary to accommodate the expansion of services in these three outpatient areas, and therefore felt that the planning initiatives could potentially not Benefit veterans.

Additionally, on February 18, 2003 the Associate Director presented the VAMHCS PI to the Clinical Center Directors and Union Representatives at the Executive Committee of the Governing Body (ECGB). It was explained that the plan called for Primary Care moving to annex space in close proximity to the existing medical center, and that Specialty Care would assume the vacated space. Medicine and Surgery were in complete agreement. There were no objections from the union representatives present.

Lastly, prior to the ECGB meeting, a separate conference was held with the Managed Care Clinical Center to discuss relocating space. Although some concerns exist, there is no major opposition to the plan since the existing space is not configured to efficient patient care.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Current referral patterns between markets will remain intact. Baltimore and Washington serve as tertiary care referral centers for the Martinsburg Market. As part of the Proximity Planning Initiative, Baltimore and Washington will continue to pursue the consolidation of small volume subspecialty services.

Domiciliary Care, currently consolidated at the Martinsburg VAMC, will retain overall VISN capacity levels but will shift a part of the Martinsburg program to the Washington Market to meet the needs of the large homeless population in the DC area.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

The VA Maryland Health Care System (VAMHCS) consists of two Maryland VA Medical Centers located at Baltimore and Perry Point and an independent 120-bed Rehabilitation and Extended Care Center on the Loch Raven campus located in Baltimore City. The VAMHCS also has six Community Based Outpatient Clinics serving the Baltimore area, Eastern Shore counties, Southern Central Maryland, and the extreme southern tip of Maryland.

Baltimore VA Medical Center located in downtown Baltimore is a tertiary care facility. It is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology as well as education and research. Comprehensive health care is provided through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

Perry Point VA Medical Center is a primary and secondary medical care, tertiary psychiatric care, and long-term care facility. Services provided include chronic and acute psychiatric care, substance abuse treatment, Post-Traumatic Stress Disorder treatment, medical intensive care, and a variety of medical and mental health ambulatory care services. The Extended Care Program includes a Nursing Home Care Unit and a Geriatric Evaluation and Management Unit.

Analysis of the CARES data shows that there is significant enrollment growth in three major counties that are in close proximity to the Baltimore Medical Center, Anne Arundel, Baltimore, and Baltimore City; which peeks in 2012 and slightly tapers off in 2022. Also the data shows that the demand for Primary and Specialty Care outpatient services greatly increases by the year 2012. A majority of this care is delivered at the Baltimore Medical Center, which has significant space gaps by the year 2012. Lastly, Mental Health Outpatient services show no growth over the next 20 years, but Mental Health programs currently do not have adequate space to care for the existing workload.

The VA Maryland Health Care System (VAMHCS) has five primary planning initiatives:

Outpatient Primary Care
Outpatient Specialty Care
Outpatient Mental Health
Inpatient Psychiatry
Construction of a new Replacement Nursing Home at the Perry Point Campus

To plan for the space gaps at the Baltimore Medical Center, space would be leased near the medical center. The existing Primary Care services would relocate to the leased space and the vacated space would be used to expand Specialty Care outpatient services.

Additionally, the plan calls for expanding services in existing Community Based Outpatient Clinics to increase Primary Care, Mental Health Care, and selected Specialty Care (Audiology, Speech, Optometry, and Podiatry). Also, collaboration with a DoD facility to expand the aforementioned services is included in this planning initiative.

Although the CARES data does not mandate a planning initiative in Inpatient Psychiatry, the VAMHCS has incorporated some renovations to building providing inpatient psychiatry services at the Perry Point Medical Center which are substandard and not in compliance with community standards. Furthermore, the VAMHCS has planned for a Replacement Nursing Home at Perry Point. The nursing home is 60 years old and not meeting community standards; however, the occupancy rate runs to capacity.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**85%**	10,185	**87%**	7,935	**86%**	7,307
Hospital Care	**91%**	6,111	**92%**	4,883	**92%**	4,176
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Baltimore

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

Executive Summary (Full analysis on CARES Portal):

As part of the CARES process, medical centers located within 35 aerial miles must complete an analysis to identify opportunities for cost efficiencies in combining clinical and administrative services, as part of the proximity planning initiatives to eliminate unnecessary duplication. This review takes into consideration that both facilities are located in large urban areas and have a significant enrollment, which projects an increase over the next twenty years. The facilities are highly complex medical institutions that serve separate and distinct, major metropolitan populations. Additionally, both facilities have numerous teaching affiliations and are major resources to medical education. Present capacity makes it impossible to absorb the other facility's workload, without duplicating space, and neither site can accommodate the required space necessary to integrate the facilities. Although both facilities are within thirty-five mile of each other, population density and traffic patterns support maintaining both facilities. Operating under the above premise, two alternatives were considered, Alternative 1, Option C, " Maintain both facilities but consolidate services/integrate facilities", and Alternative 2, Option A, "Retain both facilities with no additional consolidation of services". Alternative 1, Option C is the preferred choice as it maintains the current high level of integration and shared services while continuing to investigate clinical and administrative program efficiencies, e.g. radiation therapy, brachytherapy, warehouse functions. Alternative 2, Option A, is not preferred because although it maintains the current high level of integration and shared services the option does not identify additional future efficiencies that would result in responsible fiscal management.Both Facilities are teaching hospitals, providing a full range of patient care services, with state-of-the-art technology as well as education and research. Comprehensive health care is provided through primary care, tertiary

care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. Each facility has a 120-bed nursing home care facility that provides extended care rehabilitation, post acute care, psycho-geriatric care, hospice care, and general nursing home care. The medical centers are located in large urban areas and serve as tertiary referral centers within the VA Capitol Health Care Network. As stated in the mission overview both facilities are located in large urban areas and have a large number of enrollees, which is projected to increase over the next twenty years. Additionally, both facilities have active teaching affiliations that are major resources to medical education. At present, both facilities are highly developed, complex medical institutions that serve separate and distinct, major metropolitan populations. Currently both facilities' workload demand exceeds present capacity, both in human resources as well as in clinical space. This makes it impossible to absorb the other facility's workload, without duplicating space. Neither site can accommodate the required space necessary to completely integrate the facilities. Although both facilities are within thirty-five miles of each other, population density and traffic patterns support maintaining both facilities. The average driving time between the facilities is 90 minutes. Although both cities have mass transportation systems, there is limited crossover between the systems. CARES data shows that over 95% of veteran's seek care at the facility within their market.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

The first phase of the VA Joint Venture at Fort Meade, Fort Detrick and Aberdeen Proving Ground is an agreement being drafted to allow the VA Mental Health Service Line of VISN 5 to supply DoD with 1 Physician and 2 Psychologist who will be assigned to treat DoD beneficiaries. In exchange VISN 5 will receive up to 50 outpatient surgeries per month from DoD staff depending on the VA medical centers ability to schedule veterans in a timely fashion to receive available services and the veterans need of available services.

Continuing collaboration is ongoing to establish a Joint Venture Community Based Outpatient Clinic (CBOC) at Kimbrough Ambulatory Care Center, Fort Meade. The Baltimore Market plan identifies the need for 9.000 square feet of Primary Care/Mental Health and high volume Specialty Care (e.g. Eye, Audiology and Podiatry). A Joint Venture CBOC at Fort Meade will improve access and satisfy projected outpatient demand increases. Operational options include the VA contracting care, VA funding construction and staffing to support VA workload, and developing sharing agreements.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

The VA Maryland HCS Compensated Work Therapy Program (CWT) is presently developing a contract (MOU) with the Baltimore Regional Office (WRO) Vocational Rehabilitation and Employment (VR&E) Program Officer to provide a service by which veterans enrolled in VR&E programming would be vocationanally evaluated by the CWT program for chapter 31 feasibility purposes. The proposed collaborative program is currently in place in Martinsburg WV, who provides these contracted services to both the Baltimore Regional Office and Huntington WV Regional Office VR&E Programs. VAMHCS is currently in the process of establishing their own contract. This initiative will provide VR&E with an ability to contract with a CARF accredited CWT Program for vocational rehabilitation services while reinforcing the OneVA model of care and services.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Fort Howard is currently a CBOC under the Baltimore VAMC. Space and workload for Ft. Howard is included in Baltimore data.

Fort Howard Enhance-Use:

On June 20, 2000, Togo D. West, Jr., then Secretary of Veterans Affairs (VA), approved plans to change the mission of the Fort Howard Medical Center, a division of the VA Maryland Health Care System (VAMHCS).

The purpose of the Mission Change was to shift inpatient programs and administrative functions from the Fort Howard VA Medical Center to other VAMHCS sites where excess capacity existed and develop a Continuing Care Retirement Community (CCRC) through enhanced-use legislation. The shift was completed in September 2002 when all inpatient beds and administrative functions relocated to other VAMHCS sites.

Since the Secretary of the Department of Veterans Affairs approved the Fort Howard Mission Change prior to the implementation of the Capital Asset Realignment Enhanced-Use Services (CARES) program, the vacant square footage at Fort Howard should not have been included in the CARES database. Currently, this project is consistent with the Fort Howard facility plans and the concept of CARES. The project on the Fort Howard campus has no impact on CARES and will follow all guidance to ensure it is a stand-alone project.

The Enhance Use Legislation concept is to lease (up to 75 years) the vacant space to a community developer to build a Continuing Care Retirement Community (CCRC) for veterans and non-veterans age 55 and older. The CCRC consists of independent living, assisted living, and skilled nursing facilities. Additionally, as part of this proposal, a replacement VA outpatient clinic is to be constructed. The developer has the option to renovate or demolish any or all of the existing vacant space totaling 297,613 square feet. The only space being retained at the FHVA is 8,272 square feet currently occupied by the VA managed community based outpatient clinic. The estimated cost of demolition of existing buildings is 3.8 million dollars, and will be the responsibility of the successful Enhanced-Use contractor.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	22,178	570	27,444	5,836	5,000	-	-	114	-	-	22,558	$ (129,744,813)
Surgery	11,572	698	11,576	702	-	-	-	-	-	-	11,576	$ (1,812,055)
Intermediate/NHCU	65,561	-	65,561	-	20,324	-	-	-	-	-	45,237	$ -
Psychiatry	14,135	642	14,136	643	5,000	-	-	101	-	-	9,237	$ 18,243,183
PRRTP	383	-	383	-	383	-	-	-	-	-	-	$ (390,611)
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**113,830**	**1,911**	**119,100**	**7,181**	**30,707**	**-**	**-**	**215**	**-**	**-**	**88,608**	**$ (113,704,296)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	147,532	34,487	164,551	51,505	4,937	6,000	-	863	-	-	154,477	$ (47,403,266)
Specialty Care	170,469	72,797	195,633	97,961	20,000	3,000	-	825	-	-	173,458	$ (105,260,711)
Mental Health	102,392	378	110,585	8,571	4,424	3,000	-	923	-	-	104,084	$ (17,541,556)
Ancillary & Diagnostics	248,255	114,784	277,557	144,086	140,000	-	-	1,328	-	-	138,885	$ (53,226,072)
Total	**668,648**	**222,445**	**748,326**	**302,123**	**169,361**	**12,000**	**-**	**3,939**	**-**	**-**	**570,904**	**$ (223,431,605)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	44,748	4,951	46,921	7,124	39,797	-	-	-	-	-	39,797	(7,124)
Surgery	18,443	(1,093)	19,216	(320)	19,536	-	-	-	-	-	19,536	320
Intermediate Care/NHCU	40,192	-	40,192	-	40,192	-	-	-	-	-	40,192	-
Psychiatry	22,671	17,160	14,964	9,453	5,511	6,342	-	-	-	-	11,853	(3,111)
PRRTP	6,342	-	-	(6,342)	6,342	-	-	-	-	-	6,342	6,342
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**132,396**	**21,018**	**121,293**	**9,915**	**111,378**	**6,342**	**-**	**-**	**-**	**-**	**117,720**	**(3,573)**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	90,157	11,379	97,321	18,543	78,778	-	1,000	-	6,528	-	86,306	(11,015)
Specialty Care	184,926	85,429	196,008	96,511	99,497	-	10,000	-	54,500	-	163,997	(32,011)
Mental Health	59,961	27,769	63,491	31,299	32,192	-	7,000	-	15,382	-	54,574	(8,917)
Ancillary and Diagnostics	145,974	84,869	97,220	36,115	61,105	-	-	-	15,000	-	76,105	(21,115)
Total	**481,018**	**209,446**	**454,040**	**182,468**	**271,572**	**-**	**18,000**	**-**	**91,410**	**-**	**380,982**	**(73,058)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	58,055	-	215,821	157,766	58,055	-	-	75,000	30,000	-	163,055	(52,766)
Administrative	295,447	103,530	200,217	8,300	191,917	-	-	-	-	-	191,917	(8,300)
Other	26,224	-	26,224	-	26,224	-	-	-	-	-	26,224	-
Total	**379,726**	**103,530**	**442,262**	**166,066**	**276,196**	**-**	**-**	**75,000**	**30,000**	**-**	**381,196**	**(61,066)**

4. Facility Level Information – Fort Howard

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

No Impact

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Fort Howard Enhance-Use:

On June 20, 2000, Togo D. West, Jr., then Secretary of Veterans Affairs (VA), approved plans to change the mission of the Fort Howard Medical Center, a division of the VA Maryland Health Care System (VAMHCS).

The purpose of the Mission Change was to shift inpatient programs and administrative functions from the Fort Howard VA Medical Center to other VAMHCS sites where excess capacity existed and develop a Continuing Care Retirement Community (CCRC) through enhanced-use legislation. The shift was completed in September 2002 when all inpatient beds and administrative functions relocated to other VAMHCS sites.

Since the Secretary of the Department of Veterans Affairs approved the Fort Howard Mission Change prior to the implementation of the Capital Asset Realignment Enhanced-Use Services (CARES) program, the vacant square footage at Fort Howard should not have been included in the CARES database. Currently, this project is consistent with the Fort Howard facility plans and the concept of CARES. The project on the Fort Howard campus has no impact on CARES and will follow all guidance to ensure it is a stand-alone project.

The Enhance Use Legislation concept is to lease (up to 75 years) the vacant space to a community developer to build a Continuing Care Retirement Community (CCRC) for veterans and non-veterans age 55 and older. The CCRC consists of independent living, assisted living, and skilled nursing facilities. Additionally, as part of this proposal, a replacement VA outpatient clinic is to be constructed. The developer has the option to renovate or demolish any or all of the existing vacant space totaling 297,613 square feet. The only space being retained at the FHVA is 8,272 square feet currently occupied by the VA managed community based outpatient clinic. The estimated cost of demolition of existing buildings is 3.8 million dollars, and will be the responsibility of the successful Enhanced-Use contractor.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	5,379	(15)	114	(5,280)	-	-	114	-	-	-	-	$ 66,165,723
Surgery	-	-	-	-	-	-	-	-	-	-	-	$ -
Intermediate/NHCU	14,856	-	1,561	(13,295)	-	-	1,561	-	-	-	-	$ 151,067,177
Psychiatry	901	(36)	101	(836)	-	-	101	-	-	-	-	$ 4,618,630
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**21,135**	**(52)**	**1,776**	**(19,411)**	**-**	**-**	**1,776**	**-**	**-**	**-**	**-**	**$ 221,851,530**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	17,881	5,752	863	(11,266)	-	-	863	-	-	-	-	$ 61,073,182
Specialty Care	25,987	16,141	825	(9,021)	-	-	825	-	-	-	-	$ 84,099,112
Mental Health	9,116	(242)	924	(8,434)	-	-	924	-	-	-	-	$ 11,934,560
Ancillary & Diagnostics	30,630	4,453	1,328	(24,849)	-	-	1,328	-	-	-	-	$ 77,847,934
Total	**83,614**	**26,104**	**3,940**	**(53,570)**	**-**	**-**	**3,940**	**-**	**-**	**-**	**-**	**$ 234,954,788**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	11,188	11,188	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	1,460	1,460	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**12,648**	**12,648**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	8,941	8,941	-	-	-	-	-	-	-	-	-	-
Specialty Care	28,587	28,587	-	-	-	-	-	-	-	-	-	-
Mental Health	5,014	5,014	-	-	-	-	-	-	-	-	-	-
Ancillary and Diagnostics	19,603	19,603	-	-	-	-	-	-	-	-	-	-
Total	**62,145**	**62,145**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	-	-	-	-	-	-	-	-	-	-	-	-
Administrative	37,396	37,396	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-
Total	**37,396**	**37,396**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

5. Facility Level Information – Perry Point

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

No Impact

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Perry Point Enhance Use Legislation:

Presently, the vacant space at Perry Point is not contiguous and is composed of spaces not desirable for Enhance use due to the small sizes and locations. At this time on Enhance Use Legislation initiatives at Perry Point are not being pursued.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

VISN PI - Nursing Home Care Unit Facility Condition

To ensure a high level of patient satisfaction and service, we must be able to meet performance measures established by the Millennium Bill, which mandate facilities maintain the current level of nursing home beds. Presently, the facility condition makes it impossible to continue providing care in a building that is over 60 years old. The ability to meet community standards is ever increasingly impossible to meet each year as the building ages.

Alternative 1: Building a new replacement 130-bed nursing home (67, 000 square feet) that meet community standards.

The current nursing home in building 9H at the Perry Point VAMC (80 beds) is an aging building that is approximately sixty years old. Not only is the building dilapidated, but also is poorly configured in comparison to modern construction for this type of care. This building would be demolished and a replacement 130-

bed nursing home would be built at the Perry Point VAMHC. In addition to the exiting nursing home beds in 9H, there are an additional 50 nursing home beds in Building 14. These 50 beds in Building 14 will move to the replacement nursing home and free up space for beds to be allocated to inpatient mental health.

Alternative 2: Renovate and expand 80-bed nursing home care unit in building 9H (new construction 30,000 Square Feet).

This alternative will prevent the consolidation of the existing nursing home beds into one building, since presently the nursing home wards are split in separate and non-adjacent building. This alternative decreases staff efficiencies, and increases staffing cost. Additionally, renovation will not correct the functionality of the floor layout in building 9 H, which is antiquated and not state of the art. Renovation will not correct deficiencies such as central nursing stations, or state of the art layout for patients, because renovation is limited to the confines of the existing structure.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN										
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Medicine	5,108	(561)	5,108	(561)	1,000	-	-	-	-	-	4,108	$	4,718,952
Surgery	10	(34)	7	(37)	-	-	-	-	-	-	7	$	31,101
Intermediate/NHCU	56,995	-	70,290	13,295	21,087	-	-	-	-	-	49,203	$	(82,481,911)
Psychiatry	64,581	(1,949)	65,381	(1,149)	-	-	-	-	-	-	65,381	$	(7,119,076)
PRRTP	73	-	73	-	-	-	-	-	-	-	73	$	-
Domiciliary	13,127	-	13,127	-	-	-	-	-	-	-	13,127	$	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$	-
Total	**139,894**	**(2,544)**	**153,986**	**11,548**	**22,087**	**-**	**-**	**-**	**-**	**-**	**131,899**	**$**	**(84,850,934)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**										
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Primary Care	39,695	6,136	39,696	6,137	-	-	-	-	-	-	39,696	$	-
Specialty Care	51,935	32,585	51,935	32,585	40,000	-	-	-	-	-	11,935	$	(34,923,229)
Mental Health	45,704	(239)	45,705	(238)	-	-	-	-	-	-	45,705	$	(1,254,568)
Ancillary & Diagnostics	49,952	11,789	49,952	11,789	-	-	-	-	-	-	49,952	$	-
Total	**187,286**	**50,271**	**187,288**	**50,273**	**40,000**	**-**	**-**	**-**	**-**	**-**	**147,288**	**$**	**(36,177,797)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	10,625	3,284	8,545	1,204	7,341	-	-	-	-	-	7,341	(1,204)
Surgery	17	17	12	12	-	-	-	-	-	-	-	(12)
Intermediate Care/NHCU	112,256	33,815	138,441	60,000	78,441	-	67,000	-	-	-	145,441	7,000
Psychiatry	104,621	42,260	105,917	43,556	62,361	35,000	-	-	-	-	97,361	(8,556)
PRRTP	52,978	-	17,978	(35,000)	52,978	-	-	-	-	-	52,978	35,000
Domiciliary program	23,784	-	23,784	-	23,784	-	-	-	-	-	23,784	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**304,280**	**79,375**	**294,677**	**69,772**	**224,905**	**35,000**	**67,000**	**-**	**-**	**-**	**326,905**	**32,228**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	25,008	(2,696)	25,008	(2,696)	27,704	-	-	-	-	-	27,704	2,696
Specialty Care	70,112	56,919	16,112	2,919	13,193	-	-	-	-	-	13,193	(2,919)
Mental Health	30,165	6,666	30,165	6,666	23,499	-	-	-	-	-	23,499	(6,666)
Ancillary and Diagnostics	47,954	(3,446)	47,954	(3,446)	51,400	-	-	-	-	-	51,400	3,446
Total	**173,240**	**57,444**	**119,239**	**3,443**	**115,796**	**-**	**-**	**-**	**-**	**-**	**115,796**	**(3,443)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	20,825	-	26,620	5,795	20,825	-	-	-	-	-	20,825	(5,795)
Administrative	458,477	125,239	333,238	-	333,238	-	-	-	-	-	333,238	-
Other	152,147	-	54,747	(97,400)	152,147	-	-	-	-	-	152,147	97,400
Total	**631,449**	**125,239**	**414,605**	**(91,605)**	**506,210**	**-**	**-**	**-**	**-**	**-**	**506,210**	**91,605**

B. Martinsburg Market

1. Description of Market

a. Market Definition

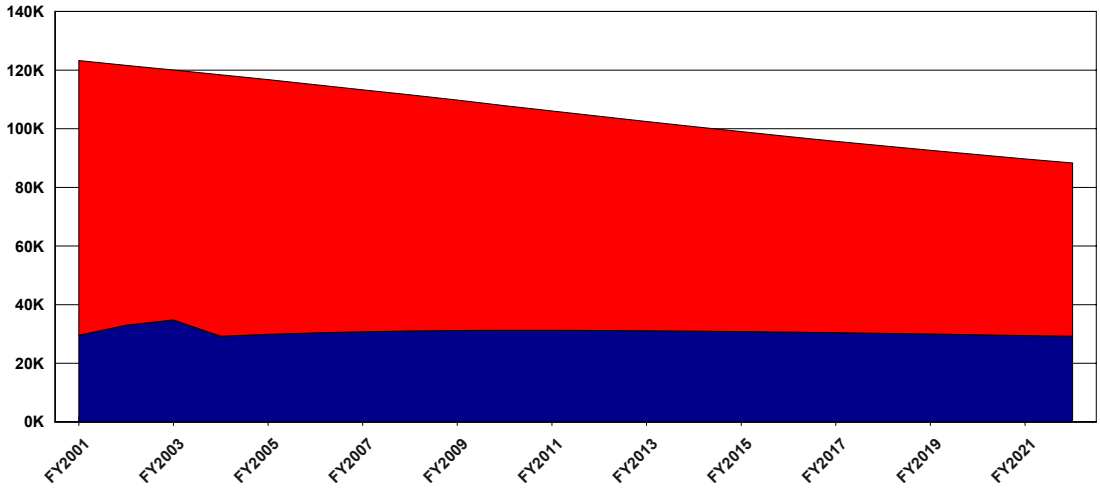
Market	Geographic Area	Rationale	Shared Counties
Martinsburg Market **Code: 5B**	5 counties in Maryland, 8 counties in Virginia, 2 counties in Pennsylvania and 8 counties in West Virginia 23 Total Counties	VAMC Martinsburg serves the Martinsburg Market. Martinsburg supports 6 CBOCs. Although the Martinsburg Market is the largest of the three markets in size, it provides services to less than 20% of the network enrollees. Of the 23 counties comprising the Martinsburg Market, 8 are urban, 8 are rural, and 7 were identified as highly rural (less than 50 vet pop/square mile). **Facilities:** Martinsburg	Martinsburg provides services to enrollees from neighboring VISN 4 counties in Pennsylvania and neighboring VISN 6 counties in Virginia, but not to the extent to justify development of a shared market.

b. Facility List

VISN : 5				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Martinsburg				
613 Martinsburg	✔	✔	-	-
613GA Cumberland	✔	-	-	-
613GB Hagerstown	✔	-	-	-
613GC Stephens City	✔	-	-	-
613GD Franklin	✔	-	-	-
613GE Petersburg	✔	-	-	-
613GF Harrisonburg	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Martinsburg Market			**Februrary 2003 (New)**			
Market PI	**Category**	**Type Of Gap**	**FY2012 Gap**	**FY2012 %Gap**	**FY2022 Gap**	**FY2022 %Gap**
	Access to Primary Care (# of enrollees)					
	Access to Hospital Care (# of enrollees)					
	Access to Tertiary Care (# of enrollees)					
PI	Specialty Care Outpatient Stops	Population Based	**50,662**	**78%**	**41,022**	**63%**
		Treating Facility Based	**67,114**	**103%**	**59,329**	**91%**
PI	Primary Care Outpatient Stops	Population Based	**31,968**	**35%**	**16,812**	19%
		Treating Facility Based	**44,162**	**42%**	**27,730**	**27%**
New PI	Mental Health Outpatient Stops	Population Based	15,573	**53%**	8,449	**29%**
		Treating Facility Based	14,726	**36%**	8,821	21%
	Medicine Inpatient Beds	Population Based	9	23%	0	0%
		Treating Facility Based	11	**27%**	3	7%
	Psychiatry Inpatient Beds	Population Based	5	19%	-1	-2%
		Treating Facility Based	9	**44%**	2	9%
	Surgery Inpatient Beds	Population Based	6	**53%**	3	**26%**
		Treating Facility Based	2	**48%**	1	24%

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

The Veteran Service Organizations (VSO) were presented an overview of the CARES concepts and program plans on July 25, 2002. The same overview was presented during the Cultural Stewardship Retreat August 12, 2002. The medical center initiated a CARES message for the telephone 'on hold' time. The message included a brief summary of CARES and identified medical center CARES coordinator and CARES communications point of contact. CARES concepts and program plans were discussed at the VA Veterans Service (VAVS) quarterly meeting on September 9, 2002. On September 26, 2002 a CARES information package was distributed to VSO members attending the quarterly meeting at the medical center. Additionally, the information package was mailed to 150 Service Representatives in the 4-state area. A package containing CARES update and program plans was mailed to 20 congressional representatives from the 4-state area on September 26, 2002. CARES brochures were placed in the medical center lobby, specialty clinics and primary care clinics throughout the medical center and at the CBOC's the same day. A CARES update was submitted to and published in the quarterly WV Legionnaire Publication during October 2002. A CARES update was provided during the Vet Center's Open House on November 14, 2002. The CARES Market Plan was presented to the VSO's during the November 21 2002 meeting. The CARES Market Plan was mailed to congressional representatives from the 4-state area on November 26 2002. A CARES News Release was submitted to the news media in the 4-state area the same day. On January 23 2003, the November and December CARES update time frames and VISN 5 Planning Initiatives were presented to the VSO's. The medical center received an inquiry from a VSO representative on February 10 2003. CARES statistics and data were in question. The information provided by the medical center satisfied the representatives' concerns. A package was mailed to the 4-state congressional representatives on March 7 2003. Information included VISN 5 Market Plan update and Planning Initiatives. Specific information relating to Martinsburg's planning initiatives was included. Three Planning Initiatives were identified: Outpatient Specialty Care, Outpatient Primary Care, and Outpatient Mental Health. A CARES News Release was provided to the 4-state media on March 13 2003. No other comments/concerns have been received. Medical Center CARES Committee, which includes our three Labor Unions, was briefed on proposed planning initiatives in December 2002. Final presentation of planning initiatives specific to Martinsburg VAMC was presented to Committee January 17 2003. There were no objections or concerns voiced from the union representatives present. Additionally, Planning Initiatives (PI's) were presented to medical center clinical and administrative Service Chief's during Director's Staff meeting in February 2003. No concerns were raised.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Current referral patterns between markets will remain intact. Baltimore and Washington serve as tertiary care referral centers for the Martinsburg Market. As part of the Proximity Planning Initiative, Baltimore and Washington will continue to pursue the consolidation of small volume subspecialty services.

Domiciliary Care, currently consolidated at the Martinsburg VAMC, will retain overall VISN capacity levels but will shift a part of the Martinsburg program to the Washington Market to meet the needs of the large homeless population in the DC area.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

The Martinsburg VAMC is located in the heart of West Virginia's Eastern Panhandle on 175 acres. The Medical Center offers a comprehensive range of services, including internal medicine, ambulatory surgery, audiology and speech pathology, dental, nursing home, nutrition, podiatry, prosthetics, women's health, mental health and rehabilitation medicine.

The Medical Center is a 99-bed primary and secondary care facility. Long-term care is provided in a 148-bed Nursing Home Care Unit and 312-bed Domiciliary. The Domiciliary Care Program has numerous treatment areas. Including a homeless program, a traumatic brain injury community re-entry program, substance abuse treatment programs, a Post Traumatic Stress Disorder (PTSD) Residential Recovery Program and long-term health maintenance.

Patient care is provided through an integrated primary care concept. Each veteran is assigned to a team of health care providers that follows the patient's care both as an inpatient and an outpatient. The Medical Center has a service area of 110,000 veterans in 23 counties in West Virginia, Maryland, Virginia, and Pennsylvania.

Analysis of the CARES data shows that there is significant enrollment growth in counties that are in close proximity to the Martinsburg VAMC. Enrollment peaks in 2012 and slightly tapers off in 2022. Also the data shows that the demand for Primary and Specialty Care outpatient services greatly increases by the year 2012. A majority of this care is delivered at the Martinsburg VAMC, which has indicated projected gaps by the year 2012. Lastly, Mental health Outpatient services show no growth over the next 20 years, but Mental Health programs currently do not have adequate space to care for the existing workload.

The Martinsburg VAMC has three primary planning initiatives: Outpatient Primary Care, Outpatient Specialty Care, and Outpatient Mental Health.

Plans to address the projected gaps at the Martinsburg VAMC are as follows.Move administrative services from the medical center to a new administrative addition. Vacated space in the medical center will be back filled with expanded specialty care clinics and expanded for Primary Care and Mental Health clinic space. Mental Health outpatient services will be integrated with Primary Care at all locations. Additionally, the plan calls for expanding services in existing CBOC's to increase Primary Care, Mental Health Care and selected high volume Specialty Care i.e. ophthalmology, oncology, podiatry, urology and orthopedics. Also, collaboration with a DoD facility to expand the aforementioned services is included in this planning initiative.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**71%**	9,501	**75%**	7,799	**75%**	7,304
Hospital Care	**74%**	8,518	**76%**	7,487	**78%**	6,428
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Martinsburg

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

The first phase of the VA Joint Venture at Fort Meade, Fort Detrick and Aberdeen Proving Ground is an agreement being drafted to allow the VA Mental Health Service Line of VISN 5 to supply DoD with 1 Physician and 2 Psychologist who will be assigned to treat DoD beneficiaries. In exchange VISN 5 will receive up to 50 outpatient surgeries per month from DoD staff depending on the VA medical centers ability to schedule veterans in a timely fashion to receive available services and the veterans need of available services.

Continuing collaboration is ongoing to establish a Joint Venture Community Based Outpatient Clinic (CBOC) with the Fort Detrick Barquist Army Health Care Facility. The Martinsburg Market identifies the need for 9,500 square feet of Primary Care/Mental Health and high volume Specialty Care services (e.g. Audiology, Eye, Ortho, Podiatry). A Joint Venture CBOC at Fort Detrick would improve access and satisfy projected outpatient demand increases. Operational options include the VA contracting for care, VA funding construction and staffing to support VA workload, and developing sharing agreements.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

The Martinsburg VA Medical Center, Mental Health Service Line Veterans Industries/Compensated Work Therapy Program (VI/CWT) has a Memorandum Of Understanding with the Huntington WV Regional Office, Vocational Rehabilitation and Employment (VR&E) Officer along with the Baltimore MD Regional Office VR&E Officer to provide a service by which veterans enrolled in VR&E programming would be vocationanally evaluated by the CWT program for chapter 31 feasibility purposes.

The benefits derived from this joint ONE VA Collaboration extend to all parties involved: the veteran, VR&E Program and the VI/CWT Program. The veteran population with severe disabilities encompassing physically and or psychiatric challenges are offered appropriate services. The VR&E Officer has readily available a CARF accredited vocational rehabilitation service which can provide extended vocational rehabilitation evaluations to veterans. The VI/CWT Programs have an opportunity to grow their programs through increased partnerships, revenue streams and referral sources.

The One VA joint collaboration developed in Martinsburg became the template for the VHA Psychosocial Rehabilitation Marketing Manager in Central Office to develop an MOU with the VBA making this project available nationally. Further, VISN5 management has determined the value of the collaboration to be such that all VI/CWT Programs are developing MOUs with their servicing VR&E Offices.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

No Impact

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

VISN PI: Inpatient Mental Health Realignment

DESCRIPTION: Initial market data projected a sizable bed reduction in terms of need for Domiciliary beds for FY2012 and 2022. However, this data was later withdrawn.

After considerable discussion with the Network it was decided that we should proceed with Domiciliary bed reduction of 77 beds due to deteriorating conditions in one of our older domiciliary bed sections. The existing 77 beds were

constructed during WWII and would require major renovation to maintain viability for continued use. The following alternatives were considered to address this identified problem:

Alternative 1 - Relocate 77 beds to the Washington DC VAMC or in space adjacent to the Washington DC VAMC.

Approximately 30% of the patients at the Martinsburg VAMC Domiciliary Care Program are residents of the Washington DC Metropolitan Area. Relocation of vets to Washington DC would allow these patients to be treated in the community of their origin, maximizing their relationships with family, significant others, and support services that they will utilize as part of their psychosocial rehabilitation. Continuity of care for these patients should be improved by maintaining their care and continued rehabilitation in one VA facility. Upon completion of the residential rehabilitation program, patients will no longer have to relocate back to their home community; and the transition from residential rehabilitation to transitional or permanent housing should be vastly improved.

It should also be pointed out that the Washington DC VAMC has identified a need for approximately 100 Domicilary Care Program beds, and transfer of 77 beds from the Martinsburg VAMC should satisfy the need for development of this capacity at the Washington DC VAMC.

Alternative 2 – Our second alternative is to establish approximately 77 beds of transitional housing under the VA's Grant and Per Diem Program in the Frederick, Maryland, area. These beds would then be accessible to all VISN 5 facilities. Although transitional housing beds do not provide the same level of care and rehabilitation as Domiciliary Care Program beds, it is felt that these beds could substantially meet the residential rehabilitation needs of most of the veterans now being served by the Domiciliary Care Program. Transitional housing coordinated carefully with primary and mental health care follow-up is considered an acceptable alternative to Domiciliary Program care.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN										
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Medicine	15,296	3,297	15,296	3,297	153	-	-	-	-	-	15,143	$	(2,274,729)
Surgery	2,166	706	2,166	706	22	-	-	-	-	-	2,144	$	(608,852)
Intermediate/NHCU	75,655	-	75,655	-	15,888	-	-	-	-	-	59,767	$	(1,232,789)
Psychiatry	9,299	2,830	9,300	2,831	-	-	-	-	-	-	9,300	$	39,387
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$	-
Domiciliary	101,554	-	79,808	(21,746)	-	-	-	-	-	-	79,808	$	63,641,177
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$	-
Total	**203,970**	**6,833**	**182,225**	**(14,912)**	**16,063**	**-**	**-**	**-**	**-**	**-**	**166,162**	**$**	**59,564,194**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**										
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Primary Care	148,764	44,162	148,764	44,162	5,951	5,000	-	-	-	-	137,813	$	6,433,981
Specialty Care	132,024	67,114	132,025	67,115	35,000	3,200	-	-	-	-	93,825	$	(672,427)
Mental Health	56,114	14,726	56,114	14,726	3,928	4,000	-	-	-	-	48,186	$	8,718,746
Ancillary & Diagnostics	159,770	57,942	159,771	57,943	50,000	-	-	-	-	-	109,771	$	(32,541,234)
Total	**496,672**	**183,943**	**496,674**	**183,946**	**94,879**	**12,200**	**-**	**-**	**-**	**-**	**389,595**	**$**	**(18,060,934)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	31,498	12,910	31,497	12,909	18,588	8,000	-	-	-	-	26,588	(4,909)
Surgery	3,560	1,435	3,559	1,434	2,125	900	-	-	-	-	3,025	(534)
Intermediate Care/NHCU	70,082	1	70,081	-	70,081	-	-	-	-	-	70,081	-
Psychiatry	18,693	6,285	18,693	6,285	12,408	4,630	-	-	-	-	17,038	(1,655)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	126,942	(12,630)	126,942	(12,630)	139,572	-	-	-	-	-	139,572	12,630
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**250,774**	**8,000**	**250,772**	**7,998**	**242,774**	**13,530**	**-**	**-**	**-**	**-**	**256,304**	**5,532**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	71,407	37,050	68,906	34,549	34,357	-	15,000	-	5,000	-	54,357	(14,549)
Specialty Care	155,525	105,512	116,343	66,330	50,013	-	31,000	-	7,000	-	88,013	(28,330)
Mental Health	43,314	17,000	39,994	13,680	26,314	-	6,000	-	3,000	-	35,314	(4,680)
Ancillary and Diagnostics	95,096	49,772	70,253	24,929	45,324	-	8,000	-	-	-	53,324	(16,929)
Total	**365,342**	**209,334**	**295,496**	**139,488**	**156,008**	**-**	**60,000**	**-**	**15,000**	**-**	**231,008**	**(64,488)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	1,000	-	1,340	340	1,000	-	-	-	-	-	1,000	(340)
Administrative	407,297	144,945	268,352	6,000	262,352	-	-	-	-	-	262,352	(6,000)
Other	76,754	-	76,754	-	76,754	-	-	-	-	-	76,754	-
Total	**485,051**	**144,945**	**346,446**	**6,340**	**340,106**	**-**	**-**	**-**	**-**	**-**	**340,106**	**(6,340)**

C. Washington Market

1. Description of Market

a. Market Definition

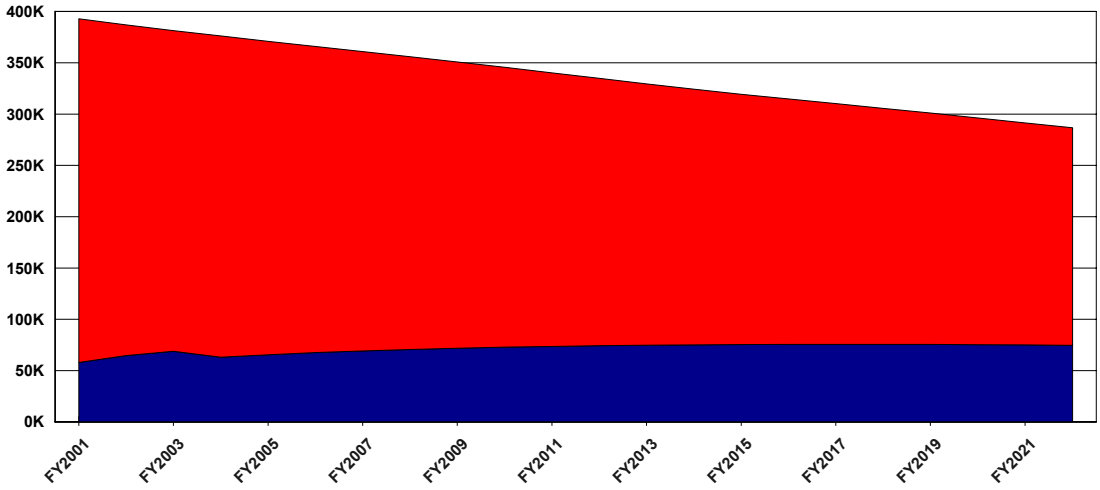
Market	Geographic Area	Rationale	Shared Counties
Washington Market **Code: 5C**	5 counties in Maryland, 9 counties in Virginia, and 1 District of Columbia encompassing the Washington Metropolitan area 15 Total Counties	VAMC Washington serves the Washington Market. Washington supports two CBOCs. VAMC Washington is the preferred site of care for all 15 counties comprising the Washington metropolitan area. (Please note: Although the Charlotte Hall CBOC is linked with the Baltimore medical center, the three rural southern counties of Prince George's County it serves were included in the Washington Market since the enrollee preferred site of care from these counties is VAMC Washington.) **Facilities:** Washington	Washington provides services to enrollees from neighboring Virginia counties in VISN 6, but not to the extent to justify development of a shared market.

b. Facility List

VISN : 5				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Washington				
688 Washington	✔	✔	✔	-
688GA Alexandria	✔	-	-	-
688GB Southeast Washington	✔	-	-	-
688GC Landover/Greenbelt (Prince Georges County)	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Washington Market			Februrary 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care (# of enrollees)					
	Access to Hospital Care (# of enrollees)					
	Access to Tertiary Care (# of enrollees)					
PI	Primary Care Outpatient Stops	Population Based	57,989	43%	48,427	36%
		Treating Facility Based	66,516	50%	51,945	39%
PI	Specialty Care Outpatient Stops	Population Based	130,713	104%	137,561	110%
		Treating Facility Based	141,652	114%	141,677	114%
PI	Psychiatry Inpatient Beds	Population Based	22	29%	5	7%
		Treating Facility Based	10	40%	0	2%
	Medicine Inpatient Beds	Population Based	21	25%	14	17%
		Treating Facility Based	19	23%	10	12%
	Surgery Inpatient Beds	Population Based	7	24%	4	15%
		Treating Facility Based	9	28%	5	16%
	Mental Health Outpatient Stops	Population Based	N/A	N/A	N/A	N/A
		Treating Facility Based	N/A	N/A	N/A	N/A

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

The Washington, DC VAMC has held meetings with Veterans Service Organizations, Union Partners, and Service Chiefs. In addition, our Public Affairs Officer has sent mailings to veterans and VSOs, and has distributed literature at local chapter meetings of various VSOs. The Mental Health Service Line has had additional meetings with Union Partners from all the medical centers in VISN 5.

The reception to our plan has been positive overall. Our service chiefs expressed their wish that specialty care at the CBOCs be of a consultative, rather than procedural nature, due to the issues involved in resident education. They stated that they felt that a key element of our residency programs in the specialty areas was that specialty care was adjacent to support services (such as MRI, CT, Pathology, etc.). We took those comments into account when designing our active alternative.

VSO reaction was also positive overall. One representative stated that he was pleased the VA recognized the increased need for inpatient psychiatry beds, and he hoped the VA did not forget the needs of the active duty members returning from the Iraq war, particularly their mental health needs.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Current referral patterns between markets will remain intact. Baltimore and Washington serve as tertiary care referral centers for the Martinsburg Market. As part of the Proximity Planning Initiative, Baltimore and Washington will continue to pursue the consolidation of small volume subspecialty services.

Domiciliary Care, currently consolidated at the Martinsburg VAMC, will retain overall VISN capacity levels but will shift a part of the Martinsburg program to the Washington Market to meet the needs of the large homeless population in the DC area.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

The workload for the DCVAMC is projected to increase significantly by FY 2022 in Primary Care/Mental Health and Specialty Care outpatient services. In addition, a need for additional inpatient Psychiatry beds and a Residential Rehabilitation program has been identified.

The DCVAMC is proposing the following plan to address these needs: 1.) Construct a 155,000 square foot Outpatient Center to address Primary Care/Mental Health, Specialty Care, and Ancillary Diagnostic. Increased multilevel parking will be required to accommodate the additional patient workload. 2.) Expand our current Community Based Outpatient Clinics (Alexandria, VA, Greenbelt, MD, and Southeast Washington, DC) to accommodate increased workload in Primary Care/Mental and high volume Specialty Care. 4.) Add a fourth CBOC in southern Prince George's County. 5.) Explore contracting for Primary Care in Fairfax City with a DoD contractor. 6.) Contract any workload we cannot accommodate to the private sector. We do not expect to utilize this option except in the case of services we do not provide. 7.) Convert space on 3C to relocate the current inpatient psychiatry unit, and expand it by 22 additional beds. 8) Open a Residential Rehabilitation facility to accommodate patients currently receiving services at the Martinsburg Domiciliary. We are exploring a joint VA-DoD collaboration at either the Armed Forces Retirement Home or at Fort Meade.

As part of our CBOC expansion, we are exploring a joint venture with the Department of Defense through shared space at the new DeWitt Army Hospital being planned for FY 2007. Prior to completion of the DeWitt Army Hospital, CBOC space will be expanded through leases in the community.

In addition, the Washington, DC VAMC will continue to work with the Baltimore VA Medical Center to find additional areas in which we can share services under our proximity initiatives. Spinal Cord Injury and Blind Rehabilitation patients will continue to be referred to VISN 6 for the former, and VISNs 4 and 6 for the latter.

We continue to work with increasing our VA-DoD collaboration. Besides contracting with Walter Reed Army Medical Center for selected specialty services, we recently signed a Memorandum of Understanding for joint medical resident education.

We have identified only one potential obstacle to our plan –resources, in terms of both funding and staff. We have been able to attract staff to our medical center, even in subspecialty areas, through the use of full-time, part-time, fee basis and contract personnel. It has become more difficult to recruit staff, primarily because of pay disparities in the private sector, though we compensate for this to some degree through teaching and research possibilities. Our market plan will enhance our medical center and help attract exceptional clinicians. The other resource needed is funding support in order to care for our veterans. Through increased space, we will be able to increase workload with greater efficiency, thus lowering our cost per patient.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**87%**	8,268	**91%**	6,683	**81%**	14,198
Hospital Care	**95%**	3,180	**95%**	3,713	**95%**	3,736
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Washington

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

Executive Summary (Full analysis on CARES Portal):

As part of the CARES process, medical centers located within 35 aerial miles must complete an analysis to identify opportunities for cost efficiencies in combining clinical and administrative services, as part of the proximity planning initiatives to eliminate unnecessary duplication. This review takes into consideration that both facilities are located in large urban areas and have a significant enrollment, which projects an increase over the next twenty years. The facilities are highly complex medical institutions that serve separate and distinct, major metropolitan populations. Additionally, both facilities have numerous teaching affiliations and are major resources to medical education. Present capacity makes it impossible to absorb the other facility's workload, without duplicating space, and neither site can accommodate the required space necessary to integrate the facilities. Although both facilities are within thirty-five mile of each other, population density and traffic patterns support maintaining both facilities. Operating under the above premise, two alternatives were considered, Alternative 1, Option C, " Maintain both facilities but consolidate services/integrate facilities", and Alternative 2, Option A, "Retain both facilities with no additional consolidation of services". Alternative 1, Option C is the preferred choice as it maintains the current high level of integration and shared services while continuing to investigate clinical and administrative program efficiencies, e.g. radiation therapy, brachytherapy, warehouse functions. Alternative 2, Option A, is not preferred because although it maintains the current high level of integration and shared services the option does not identify additional future efficiencies that would result in responsible fiscal management.Both Facilities are teaching hospitals, providing a full range of

patient care services, with state-of-the-art technology as well as education and research. Comprehensive health care is provided through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. Each facility has a 120-bed nursing home care facility that provides extended care rehabilitation, post acute care, psycho-geriatric care, hospice care, and general nursing home care. The medical centers are located in large urban areas and serve as tertiary referral centers within the VA Capitol Health Care Network. As stated in the mission overview both facilities are located in large urban areas and have a large number of enrollees, which is projected to increase over the next twenty years. Additionally, both facilities have active teaching affiliations that are major resources to medical education. At present, both facilities are highly developed, complex medical institutions that serve separate and distinct, major metropolitan populations. Currently both facilities' workload demand exceeds present capacity, both in human resources as well as in clinical space. This makes it impossible to absorb the other facility's workload, without duplicating space. Neither site can accommodate the required space necessary to completely integrate the facilities. Although both facilities are within thirty-five miles of each other, population density and traffic patterns support maintaining both facilities. The average driving time between the facilities is 90 minutes. Although both cities have mass transportation systems, there is limited crossover between the systems. CARES data shows that over 95% of veteran's seek care at the facility within their market.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

DoD Joint Resident Sharing Agreements:

Washington has recently signed a joint resident training agreement with WRAMC. This will allow either facility to arrange for clinical experience with the other in order for the residents to gain experience in a new clinical area, or additional experience at the other medical center. Several urology residents from the Washington, DC VAMC have already completed a training experience at WRAMC in lithotripsy.

DoD Joint Venture Community Base Outpatient Clinic:

Fort Belvoir plans to Replace the DeWitt Army Community Hospital, with activation in 2007. The Washington VAMC has ongoing discussions to establish a Joint Venture Community Outpatient Clinic (CBOC) at Fort Belvoir. The Washington Market plan identifies the need for 7,500 square feet for primary care/mental health and high volume specialty care services (e.g. Audiology, Eye, Ortho, Podiatry). This collaborative action will provide primary care and selected specialty services to veterans through a clinic staffed by the Washington DC VA Medical Center (DCVAMC). The CBOC will be located in space allocated by the Army in the replacement hospital for Dewitt Army Community Hospital at Ft. Belvoir Virginia. The clinic will be open 5 days a week.

Specific anticipated outcomes of the Joint Venture CBOC include the following:

a. A primary objective of the CBOC will be to provide care to eligible veterans that reside within close proximity to Fort Belvoir, Virginia. The focus of this action is to provide approximately 160,000 veterans residing in Fairfax, Arlington, and Prince William Counties expanded access to services in close proximity to their homes. These services expand upon Primary Care presently being provided by one physician and registered nurse at the Alexandria CBOC, with sporadic mental health and Audiology care. The proposed CBOC will make primary care/mental health and high volume specialty care more accessible by reducing the travel time of up to one hour for veterans residing in this southern portion of Fairfax County. This will be accomplished by adding an increased number of clinicians in the geographical area currently serviced by the VA

physician and registered nurse providing care from the Alexandria CBOC, which is co-located with the Alexandria Vet Center.

b. Because of the lower overhead associated with the CBOC being located in the new Army hospital at Ft. Belvoir, care provided to veterans will be less costly than the provision of the same care in a commercially leased area, or constructing comparable space at the DCVAMC. The proposed CBOC will enable the medical center to reduce its beneficial travel costs by shifting workload closer to the veterans' homes.

c. Patients currently seen in primary care clinics at the DCVAMC, and not enrolled at the Alexandria CBOC will have the option of being seen at the new/expanded CBOC, thus reducing congestion and the demand for parking at the medical center.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

The Washington DC VAMC Compensated Work Therapy Program (CWT) is presently developing a contract (MOU) with the Washington Regional Office (WRO) Vocational Rehabilitation and Employment (VR&E) Program Officer to provide a service by which veterans enrolled in VR&E programming would be vocationanally evaluated by the CWT program for chapter 31 feasibility purposes. The proposed collaborative program is currently in place in Martinsburg WV, who provides these contracted services to both the Baltimore Regional Office and Huntington WV Regional Office VR&E Programs. Washington VAMC is currently in the process of establishing their own contract and have received three referrals to date to establish the joint collaboration. This initiative will provide VR&E with an ability to contract with a CARF accredited CWT Program for vocational rehabilitation services while reinforcing the OneVA model of care and services.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Enhanced-Use Lease:

Washington is currently planning to construct a 155,000 sq. ft. ambulatory care wing, in addition to a 25,000 sq. ft. addition to the emergency room area. These two additions will entail the use of much of the available land area on the Washington VAMC campus. Therefore, the planned expansions preclude the addition of additional space on the Washington campus for enhanced use initiatives. We will continue to maintain open communication with the Washington Regional Office to ensure that initiatives that may arise in the future will be investigated.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

VISN PI - Inpatient Mental Health Realignment

The Washington DC Medical Center has a demand to accommodate patients in need of Domiciliary/ Residential care. There is a demand to establish 77 beds in the Domiciliary program. The Martinsburg Domiciliary has 77 beds that are in a building that is in need of repairs. The demand for domiciliary beds in Washington DC has previously been met by the Martinsburg and the VAMHCS facilities. The PI to meet the demand is for Martinsburg to close 77 beds and transfer the 77 beds, FTEE 's and workload to the DC facility. To accommodate this demand, the Washington facility plans to utilize a VA/DOD Joint Venture. Plans are to lease space from the Armed Forces Retirement Home, which is directly across from the Washington VAMC or lease space from the Ft. Meade facility. The Residential Rehab-Psych & PTSD Residential Rehab Programs have Market Base Demands that start to increase in FY02 and peaks in FY06. The demand levels off and gradually decreases up through FY 22. Martinsburg has agreed to close down 77 beds in their Domiciliary since they are in need of major renovations. Data indicates that the patients in the Washington DC market Base are going to the Domiciliary at Perry Point and at Martinsburg. Therefore Washington is loosing workload and the patients are not receiving this type of care locally. The veterans who are homeless and unstable would benefit by accessing residential care in the Washington DC market area. This venture will improve healthcare for these veterans that would access this type of care locally. Quality, as measured by satisfaction, clinical practice guidelines and preventive care measures, would be improved by this alternative. To ensure a high level of patient satisfaction and service, we must be able to meet performance measures established by VHA related to quality care, efficiency, and patient satisfaction. The inpatient services are pivotal in providing continuum of care veterans. The domiciliary will provide for services such as residential rehabilitation treatment programs, intensive case management services and transitional housing, which are addressed in this Planning Initiative. This structure for delivery of mental health services provided in the Domiciliary will reintegrate patients into the community,

and will improve mental health outcomes. This structure will also lead to a greater efficiency in cost of care.

The second alternative would be to lease space and contract out services and providers to coordinate the operations of a Domiciliary in the Washington DC area.

In order to accommodate the increased workload without constructing additional space, we will locate a facility that has a physical building and staff that could provide care for residents in a domiciliary setting. This will not necessarily be a VA-DoD joint venture as noted in Alternative 1; The entire workload, which could not be handled by the DCVAMC, would be contracted to the community. Because of the workload volume as determined by the CARES methodology we would need to contract with providers in the community. Quality oversight as well as contracting labor and oversight would be major costs associated with this alternative, and would be in addition to the actual cost of the care. The result of contracting this type of treatment facility would be costly and there would need to be VA presence to make certain that the Domiciliary Directives are being followed. The residents would be located in the community wherever adequate space is found. This could fragment the continuity and quality of care. Quality assurance measure would need to be implemented to make certain that the VA could monitor the performance of the program.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	32,061	5,964	32,061	5,964	642	-	-	-	-	-	31,419	$ (6,651,970)
Surgery	12,682	2,789	12,682	2,789	381	-	-	-	-	-	12,301	$ -
Intermediate/NHCU	95,537	-	95,537	-	57,323	-	-	-	-	-	38,214	$ (1,634,112)
Psychiatry	10,417	2,966	10,418	2,967	1,000	-	-	-	-	-	9,418	$ 11,018,445
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	21,746	21,746	-	21,746	-	-	-	-	-	$ (1,161,473)
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**150,696**	**11,718**	**172,444**	**33,466**	**59,346**	**21,746**	**-**	**-**	**-**	**-**	**91,352**	**$ 1,570,890**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	198,778	66,516	198,779	66,517	3,000	7,000	-	-	-	-	188,779	$ 14,806,788
Specialty Care	266,003	141,652	266,004	141,653	5,000	3,000	-	-	-	-	258,004	$ 1,225,644
Mental Health	140,900	486	140,900	486	1,409	2,000	-	-	-	-	137,491	$ (11,863,337)
Ancillary & Diagnostics	305,032	169,018	305,033	169,018	140,000	-	-	-	-	-	165,033	$ 9,621,009
Total	**910,714**	**377,671**	**910,716**	**377,674**	**149,409**	**12,000**	**-**	**-**	**-**	**-**	**749,307**	**$ 13,790,104**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)											
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance f 2001**								**Space Needed/ Moved to Vacant**
Medicine	65,353	7,981	65,352	7,980	57,372	-	-	-	-	-	57,372	(7,980)
Surgery	24,111	(3,124)	24,110	(3,125)	27,235	-	-	-	-	-	27,235	3,125
Intermediate Care/NHCU	44,417	1	44,416	-	44,416	-	-	-	-	-	44,416	-
Psychiatry	25,166	15,211	22,980	13,025	9,955	-	10,000	-	-	-	19,955	(3,025)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**159,047**	**20,069**	**156,858**	**17,880**	**138,978**	**-**	**10,000**	**-**	**-**	**-**	**148,978**	**(7,880)**
	Space (GSF) (from demand projections)											
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance f 200**								**Space Needed/ Moved to Vacant**
Primary Care	98,396	52,346	94,390	48,340	46,050	-	30,000	-	6,000	-	82,050	(12,340)
Specialty Care	289,678	150,823	283,804	144,949	138,855	-	70,000	-	8,000	-	216,855	(66,949)
Mental Health	76,720	33,565	75,620	32,465	43,155	-	19,000	-	3,000	-	65,155	(10,465)
Ancillary and Diagnostics	224,199	137,833	123,775	37,409	86,366	-	26,000	-	-	-	112,366	(11,409)
Total	**688,993**	**374,567**	**577,589**	**263,163**	**314,426**	**-**	**145,000**	**-**	**17,000**	**-**	**476,426**	**(101,163)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance f 200**								**Space Needed/ Moved to Vacant**
Research	62,507	-	68,274	5,767	62,507	-	-	-	-	-	62,507	(5,767)
Administrative	382,430	166,694	230,736	15,000	215,736	-	-	-	-	-	215,736	(15,000)
Other	37,902	-	37,902	-	37,902	-	-	-	-	-	37,902	-
Total	**482,839**	**166,694**	**336,912**	**20,767**	**316,145**	**-**	**-**	**-**	**-**	**-**	**316,145**	**(20,767)**